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"INNOVATIVE SOLUTIONS TO MEDICAL LIABILITY"

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Michelle M. Mello, JD, PhD, MPhil

Associate Professor of Health Policy and Law

Department of Health Policy and Management

Harvard School of Public Health

SUMMARY OF TESTIMONY

The American medical liability system performs its core functions poorly, at tremendous cost and with unfortunate effects on health care delivery.

1. *Compensation of injured patients*: Less than 5% of patients who are seriously injured by medical negligence file malpractice claims, and less than half those who claim receive compensation. Patients are especially unlikely to receive compensation if their claims are decided by a jury.

2. *Deterrence of medical error*: There is very little evidence to suggest that the threat or experience of being sued leads doctors and hospitals to make systematic improvements in the safety of the care they deliver.

3. *"Corrective justice"*: Although the system gives claimants their "day in court" and an opportunity to hold health care providers accountable for their negligence, it does not secure other important aspects of "making whole" patients who are injured, such as hearing an apology or public admission of responsibility. The system provides no corrective justice to the 95-97% of seriously injured patients who don't file a claim.

4. *Efficiency*: Exorbitant amounts of money are spent to get compensation to the few patients who receive it. On average, about 55 cents on the dollar in malpractice system costs are spent on administrative expenses.

5. *Side effects on health care delivery*: Among the unintended effects of the malpractice system on health care are "defensive medicine" behaviors, which increase the costs of care, and creation of a culture that discourages openness and information-sharing about medical adverse events.

These are fundamental problems that cannot be addressed by incremental reforms, such as damages caps. Innovative reforms are needed that can

- make compensation more accessible to patients who sustain preventable injuries;
- make the process of determining eligibility for compensation cheaper and faster;
- make compensation decisions more accurate and reliable (ideally through incorporation of the best available clinical evidence into decision making);
- make assessments of damages more consistent across similar cases; and
- make the system less threatening to doctors and encourage transparency about errors

The most promising reform approaches are those that create alternative processes for dispute resolution. Among these are the "health courts" model—moving medical injury claims to an administrative system that relies on neutral experts and has a broader eligibility standard than the tort system—and "Early Offer" programs.

I am grateful for the opportunity to speak with you today about America's medical liability system and the need for innovative solutions to improve it.

I am an Associate Professor Health Policy and Law at the Harvard School of Public Health. I am trained as a lawyer and health services researcher, and my work focuses on the empirical analysis of medical liability. I examine data on malpractice claims, insurance costs, and the organization and delivery of health services to try to understand how well the liability system is performing on its main functions and what effects it has on the quality and availability of health care.

My work has led me to conclude that our medical liability system is in need of significant reform, and that the conventional array of tort reform options will not get us where we need to be. Farther-reaching changes are required. In my testimony today, I will describe what is known about the performance of the medical liability system on several key measures, and comment briefly on reforms that would boost its performance.

Measuring the Performance of the Medical Liability System

Legal scholars think about the tort liability system as having three core functions: injury *compensation*, injury prevention (sometimes called "*deterrence*"), and *corrective justice*. Two other key criteria for thinking about how well our medical liability system performs are how *efficiently* it performs its core functions, and whether it has unwelcome *side effects* on health care delivery. I will review the evidence on each of these performance measures in turn.

1. Compensation

The most basic function of a medical liability system is to get compensation to people who are injured by medical care that falls below a particular standard of care. In our system, that standard of care is negligence. A well-functioning liability system should get fair compensation to all or most of those patients who are injured by negligence (and who desire compensation), and should give money to few or none of those patients whose injuries are not due to negligence.

This is not the way our system works. Three large-scale studies conducted by Harvard researchers over the last 15 years, involving reviews of thousands of hospital medical records and malpractice claims files from liability insurers, produced the following findings:

- Between 95% and 97% of patients who sustain serious injuries due to negligence in the hospital never file malpractice claims.[1, 2]

- Of those patients who do file claims, the majority (46%) receive no compensation.[3] Thus, overall, 1 to 2 percent of patients injured by negligence are compensated by the system.

- Patients whose claims are decided by a jury are especially unlikely to receive compensation (21% versus 61% for claims resolved out of court).[3]

- The system attracts both meritorious and non-meritorious claims.[1-3] In about a third of cases, the injury does not appear to be due to errors in care (in the judgment of an expert reviewing the medical and litigation record).[3]

- Juries are tough even on patients with meritorious cases. The odds that a claim involving a medical error is denied compensation are about 4 times higher if a jury decides the case than if the case is resolved out of court, even after controlling for injury severity and other characteristics that may differ across the two groups of claims.[3]

- The system pays both meritorious and non-meritorious claims,[4] although it is more likely to award money in meritorious cases. The system "gets it right" about three quarters of the time: 3 out of 4 non-meritorious claims are denied payment and 3 out of 4 meritorious claims receive payment.[3]

- Jury verdicts tend to produce large variation in damages awards for injuries of similar severity.[5]

Thus, the malpractice system appears to be doing a reasonable job in two specific aspects of its compensation function: (1) it is not predominantly attracting claims that are frivolous; and (2) it is usually directing compensation to meritorious claims rather than non-meritorious ones. Portraits of a system inundated with costly frivolous lawsuits are overblown. So are portraits of the system as a "lawsuit lottery," where awards are unconnected to the merits of the claim.

But to interpret this pair of findings as indicating that the medical liability system is performing its compensation function well would be misguided. There are three other factors to consider. First, a system that only helps about 1 in 50 of the patients who are eligible for compensation under the rules we have set up is not doing a good job of providing compensation.

Second, a system that awards very different amounts of money—even different amounts of "pain and suffering" damages, which should not vary according to plaintiff characteristics such as age and earning power—to plaintiffs with similar injuries raises questions about fairness in compensation.

Third, although non-meritorious claims do not predominate in the system, they do account for a third of the caseload. One likely explanation is that plaintiffs and their attorneys have some initial uncertainty about whether a case is likely to succeed. One reason for this is that it's often hard for a patient to find out what happened in an episode of medical care that had a bad outcome; filing a lawsuit may be the only way to get information. Another reason is that patients, lawyers, and even doctors may be unsure about what the legal standard of care (negligence) requires of them in particular circumstances. Even expert reviewers often disagree about what constitutes negligence. Thus, claims that ultimately prove non-meritorious may not appear so at the outset (and vice versa).

Overall, if I was to grade the malpractice system's performance on the compensation function, I'd give it a **D**.

2. Deterrence of Medical Error

The second core function of the tort liability system, and the basis on which it is most often defended, is to deter negligence and thereby prevent injuries. In theory, the system creates incentives for doctors and hospitals to take appropriate precautions to prevent injuries by imposing an economic penalty when they don't.

This theory rests on some assumptions about the organization of health care that aren't borne out in reality, and empirical evidence suggests that we don't get much deterrence out of the system. One important problem is uncertainty. Deterrence rests on the assumptions that health care providers understand what the law is asking them to do—that is, what the standard of care is—and what the penalty will be if they don't comply. But the negligence standard is ambiguous and doesn't always clearly signal what appropriate care constitutes. That's particularly true in a legal system that produces little or no written record that doctors could consult. Settlements and insurers' case files are confidential, and jury verdicts produce no written decisions. It's also hard to gauge what the penalty for negligence in a particular circumstance would be, because there is so much variation in litigation outcomes and awards.

Another key assumption is that physicians actually "feel" the economic consequences of their negligence. This tends not to be true in reality. Nearly all physicians have liability insurance. Although in theory, judgments can go beyond the limits of malpractice awards, this is extremely rare in practice. Moreover, liability insurance isn't individually experience rated, meaning that the premiums that a particular doctors pays don't change from year to year depending on whether she had a judgment against her. That makes it very different from car insurance: if we are at fault in a car accident, we pay for it the next year in higher premiums. That makes us try hard to avoid accidents. Malpractice insurance, in contrast, is generally priced only by specialty and geographic region.

Another reason doctors and hospitals don't tend to feel the consequences of negligence is that so few instances of negligent injury result in a malpractice claim. Most of the time, nothing happens.

All of these factors should make us skeptical of the deterrent value of the malpractice system. And indeed, there is very little empirical evidence that deterrence occurs in any systematic way. For example, in obstetric care, the best-studied field, research has failed to identify any differences in the quality of care rendered by obstetricians with varying histories of malpractice claims.[6] Other studies found no systematic improvement in any of several birth outcomes associated with a physician's prior claims experience.[7, 8]

Proponents of the tort system point to some isolated but impressive examples of safety improvement to rebut this argument. The leading example is the successful effort of anesthesiologists to reduce their malpractice claims by reducing the incidence of anesthesia injuries.[9]

Taking into account such anecdotes, overall, I would give the malpractice system an overall grade of **C** on its deterrence function.

3. *Corrective Justice*

The third major function of the tort liability system is to provide claimants with "corrective justice." The notion of corrective justice has two strands: a soft one that calls for financial restitution to make victims "whole" after they are injured by negligence, and a harder one that addresses a human impulse to express anger towards, condemn, and punish wrongdoers. Both strands point to having a public process to hold wrongdoers accountable for their actions.[10]

The tort liability system fits well with notions of corrective justice. Claimants gain access to a means of learning about what happened to them, showing health care providers how their actions have affected them, demanding that providers accept responsibility, receiving money, and (at least in theory) imposing a financial penalty on the provider, as well as the reputational and psychological burdens of being sued. Research indicates that malpractice plaintiffs are often motivated to sue by feelings of anger and frustration and a desire to get back at providers who have not communicated appropriately or dealt sensitively with them,[11-13] so these opportunities may be highly valued by claimants.

But other research suggests that injured patients' corrective-justice needs could be met through a less punitive process. What many malpractice claimants want is to hear the provider acknowledge that an error occurred that hurt the patient, apologize or otherwise take responsibility for what happened, and assure the patient that attempts will be made to fix the problem so that others will not be similarly hurt.[14] That does not require malpractice litigation and is not facilitated by the adversarial litigation process.

Thus, although the medical liability system serves some aspects of corrective justice fairly well, it ignores other aspects. Moreover, it's important to remember that only claimants get the benefit of corrective justice in the system, and less than 5% of patients with serious injuries due to negligence ever become claimants.

These considerations lead me to give the medical liability system an overall grade of **B** on its corrective justice function, and that is probably generous.

4. *Efficiency*

A well-performing medical liability system would perform its core functions efficiently, minimizing transaction costs and waste. Our system does not work this way. Research at Harvard shows that for every dollar paid in compensation to plaintiffs, 54 cents goes towards administrative costs—the costs of lawyers, experts, insurers, and so forth.[3] This is similar to previous estimates.[15] In part, these high costs reflect the length of litigation. On average, in our study, 3 years elapsed between the opening and closing of a claim.

Compared to other compensation systems, this is a tremendously high overhead rate. The equivalent figure for workers' compensation systems, for example, is generally in the 20-30% range.[16, 17] For many disability insurance schemes—public and private—it runs as low as 10-15%.

Another telling feature of these administrative costs is where they get spent. In our recent study of hospital malpractice claims, about 80% of the administrative costs were incurred resolving meritorious claims. This finding highlights that the process of proving negligence is lengthy and costly. It typically requires extensive legal discovery and testimony by multiple expert witnesses. The negligence standard itself is murky and contested; even in the controlled and non-adversarial context of research studies, expert reviewers frequently disagree about the presence or absence of negligence in a particular case of medical injury.[18] The pressures and biases of the litigation process only compound this disagreement.

If a more efficient system existed for determining eligibility for compensation, the money currently absorbed by administrative costs could be redirected toward compensation. A worthy target for that money would be patients who experience medical injuries that are both severe and preventable but don't receive compensation because they never file a claim.

In terms of efficiency, I would give our medical liability system a grade of **F**.

5. *Side Effects on Health Care Delivery*

It is reasonable to judge the medical liability system on the basis of its unintended effects on health care providers and the quality of care, as well as its performance on its core functions. Unfortunately, the side effects of the system are predominantly negative.[10]

One important effect is *defensive medicine*. Defensive medicine refers to physicians changing the way care they deliver care—ordering unnecessary tests, for example, or ceasing to perform high-risk procedures—in order to try to minimize their exposure to malpractice litigation.

It is not known with any reasonable degree of certainty how prevalent defensive medicine is, what its health impact is, or how much it costs the health care system.[10, 19] But there is solid evidence that it exists, and its adverse impact may be very substantial.[20, 21] Recent research in Pennsylvania by my group at Harvard suggests that doctors in specialties like orthopedic surgery and obstetrics are especially prone to this behavior, and that it gets worse during so-called "malpractice crisis" periods.[21]

A second effect that the liability system has on health care is to create friction with efforts to improve *patient safety*.[22] Building a culture of safety in medicine requires that physicians be willing to share information about injuries with systems that can use it to learn about injury prevention. Emulating other industries involving complex services that are prone to error, such as aviation and nuclear energy, the patient safety movement has sought to create mechanisms for immediate reporting of poor outcomes and analysis of what may have gone wrong.

The threat of malpractice litigation in our present liability system undercuts these efforts to encourage openness.[23] Doctors are fearful that information they provide may be used against them in court, and aware of the stigmatizing effect of a finding of negligence, which doctors tend to equate with incompetence.[24, 25] Although there is little evidence with which to gauge the role that legal fears, as opposed to other factors, have played in discouraging doctors from disclosing

and reporting medical injuries,[9] the notion that liability pressure is a major driver fits the conventional wisdom among physicians and has some empirical support.[26] Certainly, the tort system isn't making it any easier for the patient safety movement to accomplish its goals.

Overall, I would give the liability system a **D** grade for its effects on health care delivery.

Promising Options for Reforming the Medical Liability System

In summary, the medical liability system does not perform well on its major performance criteria. The most trenchant criticisms that can be made, based on the evidence gathered in research studies, are:

- Many patients with severe, preventable injuries miss out on compensation, sometimes because their legitimate claims are not paid but much more often because they never bring a claim.
- Juries do not decide the vast majority of claims, and when they do, plaintiffs usually lose.
- The process is slow and extremely costly.
- Malpractice litigation and the threat of it do not appear to result in systematic improvements in patient safety; rather, the liability system tends to thwart patient safety initiatives.

These are fundamental problems that cannot be addressed by incremental reforms, such as damages caps or pretrial screening panels. Creative thinking is needed to:

- Make compensation more accessible to patients who sustain preventable injuries;
- Make the process of determining eligibility for compensation cheaper and faster;
- Make compensation decisions more accurate and reliable (ideally through incorporation of the best available clinical evidence into decision making);
- Make assessments of damages more consistent across similar cases; and
- Make the system less threatening to doctors and encourage transparency about errors

I believe that experiments with alternatives to medical tort litigation are a good idea. How promising and successful these alternatives are will depend on their design features.

With support from the Robert Wood Johnson Foundation, my research group at the Harvard School of Public Health, in collaboration with Common Good, has been working on the design of such an experiment. Paul Barringer from Common Good will outline the major features of our approach, which we call "health courts," in his testimony today. In brief, the idea is to move

medical injury claims into an administrative system that relies on neutral experts, and expand the pool of patients who are eligible for compensation.

There are a variety of other innovative alternative dispute resolution (ADR) approaches that also warrant serious consideration. Jeffrey O'Connell will discuss one of these, the "Early Offer" program, in his testimony today.

Much is unknown about how well alternatives to traditional malpractice litigation will work. Therefore, the appropriate next step is to launch demonstration programs accompanied by careful evaluation to assess how well the alternative models have performed relative to tort litigation.

Conclusion

One of the perplexing aspects of the tort reform debates of recent years is that they rarely engage the system's true failings. Instead, they tend to fixate on traditional reforms, despite evidence that those approaches are not very helpful.[19] There are good reasons to criticize the system's performance, but it is important to do so for the right reasons, because the diagnosis informs the treatment. To be effective in improving the performance of the medical liability system, reforms must tackle the core problems that I have outlined.

That may mean rethinking our historical attachment to juries as a means of resolving malpractice disputes, especially if we are committed to the goal of getting compensation to more injured patients. Contrary to the popular wisdom, juries tend to be tough on malpractice plaintiffs. Plaintiffs lose about four in five trials. Moreover, for plaintiffs who do win, trials are an expensive way to obtain compensation because the substantial costs incurred by the plaintiff's lawyer in getting to trial are paid by the successful plaintiff through contingent fees.

Finally, the vast majority of medical malpractice claims will not go before a jury. National statistics suggest that only about 5-10% of claims reach trial, and this statistic has held fairly steady over time. In other words, approximately 55,000 of the 60,000 patients who seek compensation for medical injuries each year will resolve their claims out of court. It is imperative that the system work well for them. Therefore, in choosing among reform options, we should be careful not to hold the interests of the many hostage to the interests of the few, especially when serious questions surround how well the interests of the few are served by the current system.

Although I have painted a rather bleak picture of the medical liability system, I am optimistic about the prospects for improving it. There are good ideas waiting to be tested. I hope that you will give them serious consideration.

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